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ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 184 residents. The sample included 20 residents. Based on observation, record review, and interview the facility failed to investigate and report an allegation of abuse of 1 (#11) sampled resident.

Findings included:

- The annual Minimum Data Set dated 12/23/14 for resident #11 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment.

The 12/23/14 Care Area Assessment (CAA) regarding delirium (sudden severe confusion, disorientation and restlessness) revealed the resident had a history of behaviors and family abuse.

The care plan with a revision date of 3/3/15 revealed the resident was at risk for negative feelings about him/herself related to an extensive behavioral history, physical and sexual abuse, and no family support.

Upon request, the facility provided an investigation on 3/10/15 at 4:20 P.M. regarding the resident which included a witness statement dated 12/12/14 from a direct care staff member. The staff member reported on 12/12/14 at approximately 6:00 P.M. he/she answered the resident's call light. The resident requested for

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the nurse to come in to assist with his/her catheter. The staff member explained to the resident that he/she was able to help him/her. The resident was upset and misunderstood what the staff member had said, thinking he/she had told the resident to perform the task him/herself. The staff member used hand sanitizer but the resident got upset that the staff member had not washed his/her hands. The resident opened the door to the hallway and the staff member closed the door and asked the resident to listen to him/her. The staff member apologized to the resident and told him/her that there was a misunderstanding. The 2 had a discussion and by the end of the talk understood each other and hugged. The investigation lacked a witness statement from the resident and any other staff. The investigation lacked evidence of thorough investigation or reporting to the state agency.

The social service note dated 12/15/14 at 4:41 P.M. revealed the social worker met with the resident to discuss the incident that occurred on 12/12/14. The note revealed the resident said he/she felt frustrated, unheard, and that the staff member had grabbed his/her hands and shouted at him/her. The social worker asked the resident what the staff member shouted at him/her and the resident reported he/she was not able to understand what the staff member had shouted. The social worker told the resident the facility would follow protocol and perform an investigation and the resident said he/she did not want anyone to get into trouble. The social worker told the resident that the facility took abuse very seriously. The note showed that later in the day the resident came to the social worker's office and reported he/she wanted to put the situation in the past, did not want anyone to get into trouble

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for the altercation, that he/she had been frightened because of his/her history with abuse from his/her parent , and he/she wanted to focus on the future and not dwell on what had happened in the past. The social worker informed the resident they would follow the facility protocol. The co-director of nursing assessed the resident's wrists and did not observe concerns.

The statement dated 3/10/15 signed by administrative staff A revealed he/she received a voicemail from the resident concerning a staff member grabbing his/her wrist. Staff A sent the voicemail to administrative nursing staff E to deal with due to staff A being away from the facility at the time. Staff A wrote in the statement that he/she did not recall the phone call or sending it to staff E.

The statement dated 3/10/15 signed by administrative nursing staff E revealed he/she received an e-mail from administrative staff A containing a voicemail from the resident saying he/she needed to speak with staff A about an incident. Staff E wrote that he/she and a social worker went to the resident's room to speak with him/her about his/her concern. The resident told Staff E "it was done with." The resident said that he/she and the staff member had made up. Staff E told the resident that he/she still needed to assess his/her skin and investigate. Staff E looked at the resident's wrists and no redness, discoloration, or bruising was noted. Staff E and the social worker spoke with staff member involved in the incident and he/she became very distraught and denied hurting the resident. The statement read that staff E and the social worker spoke to the involved resident regarding the details of the event, performed an investigation,

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and spoke with the resident. After this, it was decided the staff member would not work with the resident anymore.

Observation on 3/10/15 at 3:03 P.M. revealed the resident propelled him/herself through the east common area.

Interview on 3/9/15 at 4:01 P.M. with the resident revealed a staff member had grabbed his/her wrists and shut the door.

Interview on 3/10/15 at 3:25 P.M. with administrative staff A revealed he/she was unaware of an incident of a staff member grabbing the resident's wrists. Staff A stated the director of nursing (DON) did recall the incident and said he/she completed an investigation. Staff A reported investigations of this type were done as a team and he/she would have expected to be notified of the incident. Staff A stated the DON assessed the resident's wrists, found no injury, and the resident reported to staff that he/she had overreacted to the situation so it was dropped. Staff A reported the staff involved in the incident still worked at the facility. He/she also reported typically in situations such as this the staff involved was suspended pending investigation. Staff A reported, as far as he/she knew, the staff member had never been suspended.

Interview on 3/10/15 at 4:22 P.M. with administrative staff A revealed he/she was unsure if the DON documented the conversation with the resident. Staff A stated that the DON had not completed a witness statement at the time of the occurrence. Staff A denied being able to recall knowledge of the incident but said staff E told him that he/she had forwarded the message to staff

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E.

Interview on 3/11/15 at 3:42 P. M. with administrative nursing staff E revealed he/she had received an e-mail from administrative staff A containing a voicemail from the resident. Staff E said he/she listened to the voicemail and went to talk to and assess the resident. When staff E spoke with the resident, the resident told him/her that she/he had made it up, everything was ok, and did not understand why staff E was asking about it. When staff E spoke with the involved staff member, the staff member became very upset and denied grabbing the resident. Staff E felt the best thing at the time was to ensure the staff member no longer worked with the resident. Staff E stated he/she did not document what the resident told him/her. Staff E reported the facility always investigated allegations of abuse and at the time of this incident did not feel it was abuse since there was nothing to support it and the resident denying it later. Staff acknowledged the investigation lacked documentation and this type of incident should be thoroughly investigated and reported.

Interview on 3/11/15 at 4:31 P.M. with administrative staff A and administrative nursing staff E revealed they reviewed the voicemail that had been left by the resident and it confirmed that he/she had reported to staff the same information that had been told to the surveyor in stage 1. Staff A and E reported the investigation was not thoroughly completed and was not reported but should have been.

The 9/24/13 policy provided by the facility regarding abuse investigations revealed all reports of abuse, neglect and injuries of unknown

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F 225	Continued From page 6 source should be promptly and thoroughly investigated by facility management. The 9/24/13 policy provided by the facility regarding reporting abuse to state agencies and other entities/individuals revealed all suspected violations and all substantiated incidents of abuse should be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. The facility failed to thoroughly investigate and report an allegation of staff abuse.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		

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penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 184 residents. The sample included 20 residents. Based on observation, record review, and interview, the facility failed to provide comprehensive assessment for a surgical wound upon admission for 1 resident (#49) and failed to provide a comprehensive assessment for 1 (#86) closed record resident with a documented pressure ulcer.

Findings included:

- The admission Minimum Data Set (MDS) dated 1/19/15 for resident #86 revealed the resident had long and short term memory problems and was moderately impaired with daily decision making. The resident was not at risk for pressure ulcers and did not have a pressure ulcer.

The MDS failed to identify the resident had a stage 2 coccyx pressure ulcer upon admission.

The revised skin integrity care plan dated 1/30/15 revealed staff would apply topical creams and treatment as ordered and monitor for improvement. Staff would ensure the resident's skin remained clean, dry, and free from body waste, cleanse well under skin folds, provide good pericare, apply moisture barrier as indicated/prescribed, observe for irritation, and

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report to the nurse. The resident used bilateral transfer bars, a low air loss mattress, daily skin protectant cream, would ensure adequate food/fluid intake, and remind/assist the resident to reposition hourly per a tissue tolerance test (the ability of the skin and underlying tissue to tolerate exposure to pressure without adverse effects).

The Wound Clinic Progress Notes dated 1/13/15 revealed the resident had a coccyx/sacral stage 2 pressure ulcer.

On 3/11/15 at 3:03 P.M. administrative nursing staff F stated she/he believed the coccyx ulcer was healed as the physician had ordered staff apply Zinc ointment to the affected area. She/he should have identified the stage 2 pressure ulcer to the coccyx.

The revised policy and procedure dated December 2009 titled Certifying Accuracy of the Resident Assessment revealed all personnel who completed any portion of the Resident Assessment (MDS) would sign and certify the accuracy of that portion of the assessment.

The facility failed to provide a comprehensive MDS for this resident.
- The admission Minimum Data Set (MDS) dated 1/23/15 for resident #49 revealed a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. He/she required extensive assistance from 1 staff member for bed mobility, transfer, and toilet use. The assessment indicated the resident did not have any surgical wounds upon admission.

The 1/28/15 Care Area Assessment (CAA) regarding falls revealed the resident sustained a

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fall with fracture and was hospitalized for surgical repair prior to admission.

The nurse's note dated 1/17/15 at 10:03 P.M. revealed staples were removed from the resident's right thigh, the edges were well approximated with a small amount of drainage and slight redness to the area. Staff covered the wound with a dressing and continued to monitor the resident.

Observation on 3/10/15 at 11:28 A.M. revealed the resident sat in a wheelchair at a table in the east common area drinking coffee with his/her right lower extremity elevated on the wheelchair footrest.

Interview on 3/11/15 at 2:38 P.M. with licensed nursing staff J revealed the resident had a surgical wound present upon admission to the facility. Staff J reported the MDS coordinator completed the MDS assessment and staff J expected the MDS to accurately reflect the resident's skin conditions.

Interview on 3/11/15 at 2:43 P.M. with administrative nursing staff F revealed he/she reviewed assessments and nurse's notes to determine the resident's skin condition. Staff F stated sometimes for surgical wounds he/she just asked the nurse if they were providing care for the surgical wound and if they were not then staff F did not code the wound on the MDS. Staff F stated he/she should have coded the MDS to show a surgical wound since the nurse's notes indicated staff was providing care for the surgical incision.

Interview on 3/11/15 at 3:42 P.M. with

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F 278	Continued From page 10 administrative nursing staff E revealed he/she expected the MDS to be accurate. The policy provided by the facility with a revision date of December 2009 regarding certifying accuracy of the resident assessment revealed all personnel who completed any portion of the MDS must sign and certify the accuracy of the portion of the assessment. The facility failed to ensure accuracy of the MDS for this cognitively impaired resident with a surgical incision present upon admission.	F 278		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 184 residents. The sample included 20 residents. Based on observation, record review, and interview the facility failed to thoroughly assess the skin, consistently document their findings, and prevent the development of an unstageable pressure ulcer for 1 (#49) sampled resident of 3 residents reviewed for pressure ulcers.	F 314		

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Findings included:

- The admission Minimum Data Set (MDS) dated 1/23/15 for resident #49 revealed a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. He/she required extensive assistance from 1 staff member for bed mobility, transfer, and toilet use. The resident was frequently incontinent of bladder and was at risk for the development of pressure ulcers but had none at the time of the assessment.

The 1/28/15 Care Area Assessment (CAA) regarding pressure ulcers revealed the resident had a potential for pressure ulcer development related to impaired mobility from a femur (thigh bone) fracture and wore an immobilizer. Staff provided a pressure relief mattress and turning every 2 hours.

The initial care plan dated 1/20/15 revealed staff provided repositioning every 2 hours and the resident wore an immobilizer but lacked the location of the immobilizer. Staff reminded the resident to reposition. Staff avoided restrictive clothing, kept his/her heels free from the bed surface, provided a pressure redistribution mattress and seat cushion, kept skin clean and dry, applied moisture barrier after incontinent episodes, encouraged fluids, and observed for changes. Staff inspected the skin under braces, splints, and medical devices.

The comprehensive care plan initiated 1/23/15 revealed the resident was at nutritional risk related to chronic obstruction pulmonary disease (COPD; progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression

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(abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), hip pain, and poor appetite. Staff provided a nutritional supplement, repositioning every 2 hours, and elevation of the resident's legs.

The care plan revised 1/29/15 revealed staff provided pressure wound treatment related to impaired skin integrity from a brace on his/her right lower extremity. Staff monitored for signs and symptoms of healing and applied dressings to open blisters.

The care plan revised 2/3/15 revealed the resident had impaired skin integrity related to an unstageable wound on his/her right posterior calf. Staff provided treatments as ordered, provided a pressure redistributing cushion to his/her wheelchair, positioned the resident off the affected area, off-loaded his/her heels while he/she was in bed, provided pain relief, elevated his/her lower extremities while he/she sat unless it was contraindicated, kept his/her leg as straight as possible, and discontinued his/her immobilizer on 2/4/15. The resident was being evaluated by a wound physician. Staff monitored for signs and symptoms of improvement or deterioration and wound status weekly in the wound book. An addition to the care plan dated 2/24/15 revealed staff provided a pressure redistributing mattress to his/her bed, repositioned him/her every 2 hours, and the resident ' s primary care physician managed his/her edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The Braden Assessments (scale for predicting pressure sore risk) dated 1/23/15, 1/28/15,

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1/31/15, 2/7/15, and 2/14/15 revealed scores of 13 to 14, indicating the resident was at moderate risk.

The initial nutrition risk assessment dated 1/23/15 revealed the resident weighed 114 pounds. He/she was at risk for weight fluctuations due to edema (swelling resulting from an excessive accumulation of fluid in the body tissues) and was at risk for pressure ulcers due to limited mobility, use of an antidepressant (medication used for the treatment of depression), and the presence of a surgical wound.

The laboratory blood test results dated 1/29/15 revealed a low albumin (blood test used to measure the amount of protein in the blood, used in part to determine a person ' s nutritional status) level of 3.0 when a normal range was 3.4 to 4.8 and a low total protein level of 5.2 when the normal range was 6.4 to 8.3. These results indicated the resident ' s nutritional status was compromised putting him/her at greater risk for skin impairment.

The skin section of the skilled nursing daily assessments dated 1/23/15 through 1/27/15 showed he/she had generalized bruising to his/her upper and lower extremities but lacked evidence of areas of concern to the resident right posterior (directed toward or situated at the back) calf.

The skin section of the skilled nursing daily assessment dated 1/28/15 revealed staff noted 2 open areas to the resident ' s right ankle measuring 2 centimeters (cm) by (x) 1 cm and 5 cm x 2 cm.

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The nurse ' s note dated 1/28/15 at 10:22 A.M. revealed a physician assessed the resident and ordered staff to apply meplix (a type of wound dressing) to 2 open areas on the resident ' s right posterior calf.

The skin section of the skilled nursing daily assessment dated 1/29/15 revealed the resident had wound dressings to 2 open areas on his/her right posterior calf.

The nurse ' s note dated 1/29/15 at 6:00 P.M. revealed the facility received new orders due to an open area on the resident ' s right posterior calf: 1.) check under the immobilizer every shift, 2.) immobilizer on during the day and off at night.

The skin section of the skilled nursing daily assessments dated 1/30/15 through 2/3/15 failed to address the open areas to the resident ' s right posterior calf.

The wound evaluation flowsheet for the resident revealed he/she acquired a pressure ulcer in the facility to his/her posterior calf dated 2/3/15. The following dates and information were on the flowsheet:
2/3/15: Week 1. The wound was unstageable and measured 9.6 cm x 1.4 cm x unable to determine/assess (UTA). The wound presented with heavy, thick serosanguineous (semi-thick reddish drainage) exudate (is fluid, such as pus or clear fluid, that leaks out of blood vessels into nearby tissues) with a mild odor and the wound bed was 100 percent (%) covered in slough (dead tissue, usually cream or yellow in color).
2/10/15: Week 2. The wound was unstageable and measured 8.5 cm x 1.7 cm. The wound presented with a small amount of thick

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serosanguineous exudate without odor and the wound bed was 100 % covered with yellow adherent slough.
2/17/15: Week 3. The wound was unstageable and measured 7.3 cm x 1.8 cm x UTA. The wound presented with a moderate amount of thick serosanguineous exudate and the wound bed was covered with 75 % with slough and 25 % with epithelial (tissue that forms a thin protective layer on exposed bodily surfaces and forms the lining of internal cavities, ducts, and organs) tissue.
2/24/15: Week 4. The wound was unstageable and measured 7 cm x 1.9 cm x UTA. The wound presented with a heavy amount of thin serous (clear) exudate and the wound bed was covered with 75 % slough and 25 % epithelial tissue.
3/3/15: Week 5: The wound was unstageable and measured 7.6 cm x 1.5 cm x UTA. The wound presented with a heavy amount of thin serous exudate and the wound bed was covered with 75 % slough and 25 % epithelial tissue.

Observation on 3/10/15 at 5:04 P.M. revealed the wound physician measured the resident ' s pressure wound to his/her right posterior calf. The physician removed the old dressing and revealed 2 open areas measuring 1 cm x 2 cm and 4.3 cm x 1 cm x 1.1 cm. During the observation the physician stated the wound had separated into 2 wounds.

Interview on 3/10/15 at 5:10 P.M. with physician GG revealed he/she frequently saw wounds that had developed from use of immobilizers and braces. He/she recalled the resident had substantial edema when admitted to the facility and felt that may have contributed to the pressure ulcer development. He/she stated the facility may

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have discovered the wound sooner if the skin under the immobilizer had been thoroughly monitored.

Interview on 3/11/15 at 9:17 A.M. with administrative nursing staff D revealed he/she acknowledged documentation lacked evidence of the presence of the resident ' s pressure wound on some of the skilled nursing daily assessments. Staff D acknowledged the wound was not discovered by staff until it was unstageable and large in size, he/she stated he/she thought staff would have been caught it sooner.

Interview on 3/11/15 at 1:22 P.M. with licensed nursing staff I revealed the nursing staff were to remove all clothing and devices when performing skin assessments. He/she stated the skin assessment should include documentation of any pressure ulcers, bruises, blisters, and/or skin tears.

Interview on 3/11/15 at 2:31 P.M. with direct care staff P revealed he/she worked with the resident upon admission and remembered that he/she wore an immobilizer on his/her leg.

Interview on 3/11/15 at 2:38 P.M. with licensed nursing staff J revealed the nursing staff were to remove any immobilizers every shift to complete a full skin assessment. Staff J reported he/she was not working when staff discovered the resident ' s wound but he/she was under the impression it started as a blister. Staff J said he/she would expect the skin section of the skilled nursing daily assessment to show if a blister or wound was present.

Interview on 3/11/15 at 3:42 P.M. with

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F 314	Continued From page 17 administrative nursing staff E revealed he/she expected the nursing staff to remove devices such as splints and assess the skin under the devices. Staff E expected the skin assessments to include all findings on the residents ' skin. The policy provided by the facility with a revision date of 12/2013 regarding pressure ulcer prevention and management revealed staff assessed residents for risk of developing pressure ulcers on admission then weekly for four weeks, quarterly, and upon indication of a significant change. The policy also shows the licensed nurse performed skin assessments on residents on skilled care daily, and all other resident weekly. The facility failed to provide a policy regarding skin assessments. The facility failed to prevent the development of a large, unstageable pressure ulcer and failed to consistently assess and document regarding the wound until the resident was reviewed by a wound physician for this cognitively impaired resident with a known risk for skin impairment.	F 314		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328		

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F 328	Continued From page 18 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: The facility identified a census of 184 residents, with 7 residents reviewed for medication administration. Based on observation, interview, and record review the facility failed to meet professional standards for administration of medications via enteral tube. Findings included: - Resident #247 received medications via enteral tube (a tube placed into the stomach through the abdominal wall to receive medications and feedings). On 3/10/15 at 4 P.M. licensed nursing staff H administered a crushed pill of Famotidine 20miligrams (mg) for the treatment of GERD (gastro-esophageal reflux disease.) Staff H immediately administered Keppra 500mg/5ml (milliliters) for seizures to the resident. Observation of the procedure revealed staff H checked auscultated (listening to the internal sounds of the body, using a stethoscope) the residents bowel sounds, checked for residual (instilling air and listening to a gurgling sound with stethoscope), placed water in both medication cups, gave the resident approximately 100 milliliters (ml) water via the enteral tube, and instilled both medications, flushed the tube with additional water, instilled the 8 ounces of supplemental feeding to the resident, and followed with 200 ml of water. Interview on 3/10/15 at 4:40 P.M. licensed staff H stated he/she was aware that both medications	F 328		

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F 328	Continued From page 19 were given without flushing between the medications. Review of the facility policy for enteral tube medication administration not dated revealed medications were not mixed together. Each medication is mixed with water or other suitable diluent if water is unacceptable before administration. Each medication was administered separately to avoid interaction and clumping. The enteral tubing was flushed with at least 5 ml of water between each medication to avoid physical interaction of the medications. Interview on 3/11/15 at 4:30 P.M. with administrative nursing staff D confirmed staff should follow the policy for enteral tube medication administration, and give the flush between each medication. The facility failed to follow the facility policy to administer medications to this resident receiving medications by enteral feeding tube.	F 328		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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by:
The facility identified a census of 184 residents with one central kitchen and 7 galley kitchens. Based on observation, interview, and record review the facility failed to store, prepare and serve food under sanitary conditions.

Findings included:

- During the initial tour with dietary staff DD on 3/9/15 at 8:15 A.M. review of the range hood over the stove revealed the glass light globes and panels over the stove area were laden with grease. Review of the cleaning schedule for the hood revealed staffs were to clean it on a biweekly basis. Interview on 3/11/15 at approximately 11:30 A.M. dietary staff DD stated there was no documentation to support the hood was cleaned on a biweekly basis.

Continued tour of kitchent revealed the following:
- the bakery freezer had buns that were open and undated.
- the dairy walk in refrigerator had a pan of yellow jello salad that was not dated or covered.
-the glass reach in refrigerator had a bag of lettuce that was open and not dated, the lettuce was turning brown,
-the reach in cooler had a standing cart that had a plastic cover with the date of 3/1/2015 on an orange sticker., On the shelves of the cart were 1 tray identified by dietary staff DD of ground sausage covered with plastic wrap and not dated, 2 trays of semi-cooked bacon covered with plastic wrap and not dated. In the meat freezer a package of frozen hamburger buns were open and not dated.

Review of the facility policy for food and supply

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storage procedures dated revised 1/14 revealed cover, label and date unused portions and open packages. Use the orange label, and complete all sections on the label.

The area under the prep table contained potato pearls opened and not dated, french fried onion crisps open and not dated, a box of grits open and not dated, and a box of cream of wheat open with the contents exposed sitting on the lower shelf.

Observation on 3/11/15 at approximately 11:45 A.M. dietary staff FF removed pans from the transport hot cart using a towel to place items on the steam table, as staff transferred items, the towel dipped into the water in the steam well. During the process of transferring pans, the pureed barbeque sauce pan fell to the floor, and the saran wrap cover made contact with the floor's surface. Dietary staff FF picked the pan up and placed it on the steam table ledge, and later placed the pan of sauce into the steam table well, dietary staff punctured the saran wrap that came in contact with the floor to take the temperature of the sauce with a thermometer. Staff confirmed the towel that was used to remove the pans from the hot transfer cart was used to wipe barbecue sauce from the floor and was placed on the steam table service ledge.

On 3/11/15 at 4:15 P.M. dietary staff EE stated staff should have changed the wrap on the barbecue sauce prior to taking the temperature, he/she should not have place the towel used to wipe up the floor on the steam table service ledge.

The facility failed to store, serve and prepare food

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F 371	Continued From page 22 in a sanitary manner.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility had a census of 184 residents The sample included 20 residents. Based upon observation record review and interviews the facility failed to respond to the consultant pharmacist irregularities in a timely manner for 1 (#24) of 6 residents sampled for unnecessary medications. Findings included: - Resident #24's electronic record identified the resident had diagnoses that included depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The resident #24's annual Minimum Data Set	F 428		

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(MDS) dated 12/7/14 identified the resident scored 11 (moderately impaired cognition), had no behaviors and received anti-anxiety and antidepressant medications 7 of the 7 days during the assessment period.

The resident's Psychotropic Care Area Assessment (CAA) dated 10/14/14 documented the facility addressed the potential side effects of the anti-anxiety and anti-depressant medications the resident received.

The resident's care plan dated 12/10/14 addressed the resident had a diagnosis of dementia with psychosis, anxiety and depression and staff monitored the effectiveness of the resident's anxiety and depression medications.

Review of the resident's March 2015 Medication Administration Record (MAR) identified the resident received Klonopin (an anti-anxiety medication) 0.25 milligrams (mg) three times a day.

Review of the resident's January, February and March 2015 behavior monitoring sheets lacked evidence to support the facility monitored the targeted behavior for the Klonopin each shift and/or charted by exception.

The resident's medication regimen reviews included the consultant pharmacist made nursing recommendations regarding "holes" in the resident's Klonopin monitoring sheets on 6/12/14, 9/4/14, 10/20/14, 12/15/14 and 1/20/15.

On 3/10/15 at 11:30 A.M. the resident sat in his/her wheelchair and no inappropriate behavior was observed.

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F 428	Continued From page 24 On 3/11/15 at 8:30 A.M. licensed nurse K stated staff on the south side of the facility documented whether or not the resident exhibited targeted behaviors each shift and did not chart by exception (documentation only if a behavior was exhibited). On 3/11/15 at 10:50 A.M. pharmacy consultant II stated a couple of months ago consultant pharmacist staff discussed holes on residents' behavior monitoring sheets and the development of a policy and procedure regarding charting by exception or documenting behaviors on each shift. He/she stated consultant pharmacist staff discussed with the facility to develop a policy and procedure regarding charting by exception or documenting behaviors each shift. Pharmacy consultant staff II stated the facility decided to document by exception and the facility revised the behavior monitoring policy and procedure during the month of 11/14 to include charting by exception regarding resident's behaviors. On 3/11/15 at 10:55 A.M. administrative nursing staff E stated during the month of November 2014 the facility's behavior monitoring policy was revised to include charting by exception regarding resident's targeted behavior to address the consultant pharmacist irregularities regarding the "holes" on resident's behavior monitoring forms. On 3/11/15 at 11:14 A.M. administrative staff A stated the facility's behavior monitoring policy and procedure was not revised in 11/2014. He/she stated the facility's behavior monitoring policy and procedure was dated 2/2013.	F 428		

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F 428	Continued From page 25 On 3/11/15 at 11:20 A.M. administrative staff A stated in order to address the consultant pharmacist irregularities staff charted by exception resident's behavior. He/she confirmed staff on the south side of the facility continued to chart on the behavior monitoring forms each shift. The facility's Behavior Assessment and Monitoring Policy approved 2/19/2013 included staff documented the number and frequency of episodes about resident's specific problem behaviors. The facility failed to address the consultant pharmacist irregularities in a timely manner.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		

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isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 184 residents. Based on observation, record review, and interview the facility failed to disinfect the glucometer between residents and failed to disinfect frequently touched surfaces when cleaning resident rooms.

Findings included:

- Observation on 3/10/15 at 11:19 A.M. of direct care staff O revealed he/she performed accuchecks on 2 residents and failed to clean the glucometer between uses.

Interview on 3/10/15 at 11:30 A.M. with direct care staff O revealed he/she cleaned the glucometer at the end of his/her shift.

Interview on 3/11/15 at 3:42 P.M. with administrative nursing staff E revealed staff

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should clean the glucometer between each use.

Interview on 3/11/15 at 4:12 P.M. with administrative nursing staff D revealed he/she expected staff to clean the glucometer between each resident.

The policy provided by the facility with a revision date of August 2012 regarding blood sampling (finger sticks) revealed staff were to ensure the blood glucose meters intended for reuse were cleaned and disinfected between resident uses.

The facility failed to ensure the glucometer was disinfected between each resident.

- Observation on 3/11/15 at 10:30 A.M. revealed housekeeping staff Y cleaned a resident room and failed to clean/disinfect frequently touched surfaces including door knobs, light switches, and the call light.

Interview on 3/11/15 at 10:55 A.M. with housekeeping staff Y revealed he/she acknowledged frequently touched surfaces were not cleaned and stated staff cleaned those surfaces every other day and upon discharges.

Interview on 3/11/15 at 11:18 A.M. with environmental services staff Z revealed housekeeping staff should disinfect frequently touched surfaces daily with room cleanings.

The 5/1/13 policy provided by the facility regarding 10-step cleaning process revealed staff were to sanitize all horizontal surfaces and ensure "high touch" points were covered.

The facility failed to follow the facility policy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 28 ensure frequently touched surfaces were sanitized when cleaning a resident room.	F 441		